NOAA 56-61
(4-02)

OBSERVER DIVER MEDICAL HISTORY REPORT

NOTE: This form is to only be used by divers desiring to be temporarily certified as NOAA Observer Divers. All other NOAA divers should not use this form to report any medical information, but should use the appropriate forms listed in the NOAA Diving Program Regulations.

1. NAME (Last, First M.I.)		2. SOCIAL SECURITY NUMBER	3. DATE OF EXAM
4. AGENCY		5. DIVING UNIT	6. WORK PHONE
7. DATE OF BIRTH	8. AGE	9. SEX ☐ MALE ☐ FEMALE	10. WORK ADDRESS
11. CURRENT MEDICATION & DOSAGE			12. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS
13. PRESENT HEALTH			
14. ALLERGIES (List All)			15. RATING OR SPECIALTY OF EXAMINER

16. PAST/CURRENT MEDICAL HISTORY *(Do you have or have you ever had the following)*

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Trouble with your ears, including ruptured ear drum, difficulty clearing your ears, or surgery	☐	☐	Heart disease or high cholesterol	☐	☐	Surgery of any kind (if yes, explain below)	☐	☐
			Diabetes mellitus	☐	☐	Hospitalization for any reason (if yes, explain below)	☐	☐
Decompression sickness, embolism, or other diving malady	☐	☐	Anatomical heart abnormalities including patent foramen ovale, valve problems, etc	☐	☐	Take any medications (list above)	☐	☐
Depression, anxiety, claustrophobia, or any other psychiatric disorder	☐	☐	Heart rhythm problems	☐	☐	Allergic to any medications, foods, or environmental factors (list above)	☐	☐
			Need for a pacemaker	☐	☐			
Eye surgery	☐	☐	Difficulty with exercise	☐	☐	Smoke (if yes, how much)	☐	☐
Loss of consciousness for any cause	☐	☐	High blood pressure	☐	☐	Drink alcoholic beverages (how much)	☐	☐
Epilepsy, or other seizures, convulsions, or fits	☐	☐	Collapsed lung	☐	☐	Family history of high cholesterol	☐	☐
Stroke or any neurological deficit	☐	☐	Asthma	☐	☐	Family history of heart disease or stroke	☐	☐
Recurring neurologic disorders, including transient ischemic attacks	☐	☐	Exposed to a person with tuberculosis (TB), or have persistent cough, sweats, or weight loss	☐	☐	Family history of diabetes	☐	☐
						Family history of asthma	☐	☐
Aneurysms or bleeding in the brain	☐	☐	Tuberculosis or positive TB test	☐	☐	Substance abuse, including alcohol	☐	☐
Trouble with dizziness	☐	☐	Other lung diseases	☐	☐	Use any illegal substances	☐	☐
Head injury	☐	☐	Pregnancy	☐	☐	Thyroid trouble	☐	☐
Disorders of the blood or easy bleeding	☐	☐	Date of last menstrual period:			Bone, joint, or other deformity	☐	☐

17. EXPLAIN IN DETAIL "YES" ANSWERS TO ANY OF THE ABOVE QUESTIONS

I certify that the above answers and information represent a true, accurate, and complete description of my medical history.

18. TYPED OR PRINTED NAME OF PATIENT	19. SIGNATURE	20. DATE

21. EXAMINER SUMMARY OF DEFECTS

Signature certifies the examiner has reviewed the above medical history and found no contraindications to scuba diving.

22. TYPED OR PRINTED NAME OF EXAMINER	23. SIGNATURE	24. DATE